

**HEALTH CARE FACILITY ASSURANCES
FOR J-1 VISA WAIVER APPLICATIONS**

(Completion of this form satisfies the employer assurances required under U.S. Department of State regulations 22 CFR 41.63. Failure to complete this form will result in an application being deemed ineligible for a state recommendation for a J-1 visa waiver.)

The health care facility requesting this J-1 visa waiver recommendation, assures that each of the following statements are factual.

The facility's authorized representative must initial each statement and must sign and date the bottom of this Health Care Facility Assurances form.

- _____ 1. The practice address stipulated in the employment agreement is in a federally designated Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA).
- _____ 2. As indicated in the employment agreement, the applicant physician will provide primary medical services for a minimum of 40 hours per week, for a period of three years, and only in a HPSA or MUA.
- _____ 3. The applicant physician will begin practicing at the health care facility within 90 days of the effective date of the J-1 visa waiver.
- _____ 4. The health care facility commits to make reasonable effort to retain the applicant physician for at least three years, e.g. an employment package that is competitive for the service area and the physician's qualifications/performance.
- _____ 5. The health care facility accepts Medicaid and Medicare eligible patients, as well as medically indigent patients.

NOTE: There are consequences for employer failure to comply with Wisconsin J-1 visa waiver program requirements (see page 4 of the application guidance).

I, the authorized representative of the health care facility submitting this application, do assure that each of these statements are factual.

Print Name and Title of Authorized Facility Representative

Print Name of Health Care Facility

SIGNATURE - Authorized Facility Representative

Date Signed